Safe Futures Maryland
Center for Prevention of Intimate Partner Violence
The Family Crisis Center of Baltimore County, Inc.

FAMILY CRISIS CENTER
OF BALTIMORE COUNTY

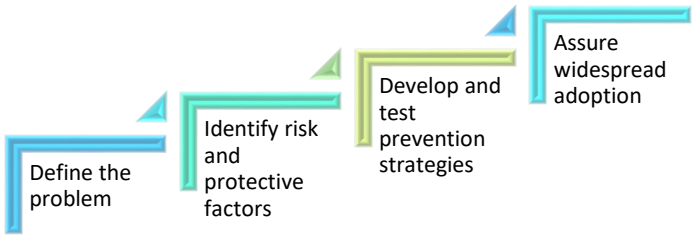
A Public Health Approach to Domestic Violence/Intimate Partner Violence

The focus of public health is to improve the safety, health, and well-being of entire populations. Public health approaches use a systematic, scientific, multi-disciplinary approach to identify and control the incidence and prevalence of a public health problem, to prevent new cases from occurring, and to mitigate the impacts and consequences of occurrences. Public health approaches include prevention, health promotion, and monitoring. Public health has a role in building capacity within communities to implement evidence-based practices, programs, and policies and to facilitate the scale-up of effective prevention strategies. This is a broad and encompassing approach to tackling a complex issue such as violence.

Much of the service delivery system in the DV/IPV sector is one of response, particularly to crises involving high risk, high severity situations. While this important work must continue, it is equally important that DV/IPV agencies begin to expand the work "*upstream*," to lessen the "*downstream*" consequences. This refers to a popular analogy used in public health, involving villagers rushing to the river to rescue victims from drowning. As the villagers work to pull people out of the swift waters, some begin to ask why there are so many people drowning in the river. As a few rescuers shift their attention upstream to investigate, they find that a natural bridge has eroded and villagers attempting to cross the river are falling into the water and being carried downstream. To work *upstream* to repair the bridge or divert foot traffic becomes an obvious solution, by preventing individuals from ending up in the waters rushing *downstream.*

In order to work upstream, it is important for DV/IPV agencies to widen their lens to include a prevention viewpoint across services and systems. This includes engaging in opportunities to collaborate with partners in *multi-tier approaches* to violence intervention. This includes not only targeting those *at-risk* but also working to *reduce and prevent the risks of interpersonal violence* within the population . In DV/IPV, agencies have deferred to or depended upon the criminal justice system and the victim services system, which, arguably have become service and incarceration industries. Solutions involve integrating prevention into systemic level changes that address social and economic factors that contribute to violence in order to reduce the incidence and prevalence of interpersonal violence in our communities.

The public health approach to violence prevention includes **four steps** that seek to answer the questions "where does the problem begin?" and "how can we prevent it from occurring in the first place?" These steps are sequential and involve multiple people, organizations, and systems in the progression.



Step 1: Define the problem through systematic data collection. What is the problem? Collect data from a variety of sources on who, what, when, where, and how. Decide the scope and the burden of the problem. Provide ongoing surveillance and monitoring.

Step 2: Identify the risk and protective factors that impact violence. What are the causes and correlates? Why does violence occur and whom does it affect? Why does one person or community experience violence when another does not? What increases the risk and what decreases the likelihood of violence in the presence of risk?

Step 3: Design, implement, and evaluate interventions. Are there existing effective strategies, or what resources are needed to develop a new strategy based on what was learned in steps 1 and 2? What research partners can be located to test and evaluate what works, for whom? Did the strategy do what was intended? How is this information to be shared with others?

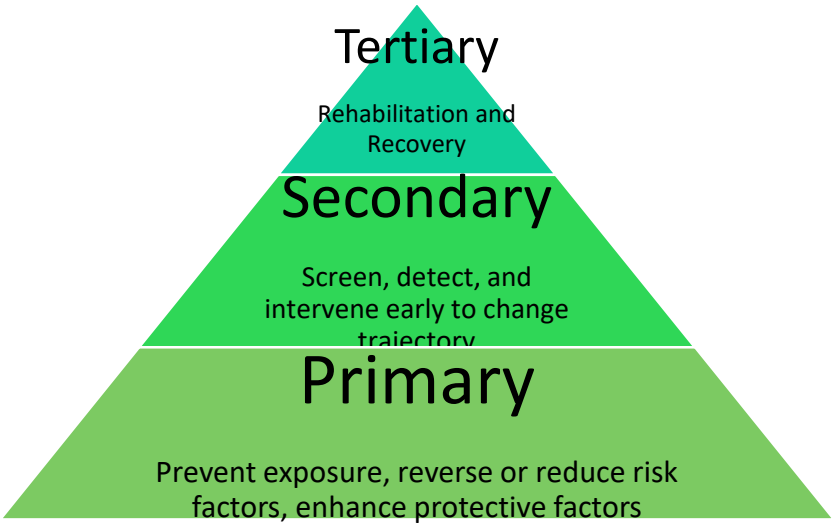
Step 4: Disseminate information about the strategies that have been shown to be effective. Who would benefit from this strategy? Locate and contribute to registries for evidence-based practices. Obtain training and technical assistance. Scale up effective programs and policies. Continue to evaluate outcomes, components, and cost-effectiveness to assure they produce the desired effect of preventing violence. What support and resources are available for ongoing implementation, monitoring, and evaluation?

A Public Health Framework for Prevention: An Evolution Story

A common model of prevention used for many years in public health is represented as pyramid, with primary prevention standing at the base of the pyramid, including efforts to prevent a problem before it occurs. *Primary prevention* efforts typically involve universal measures for the whole population, or targeted interventions to segments of the population known to be "at risk." Primary prevention aims to broaden the scope of intervention to impact more people and increase cost-effectiveness by preventing the need for more costly interventions. At the top of the pyramid is *a tertiary level of prevention*, providing services to individuals in which the problem has already occurred and progressed. Efforts at the top of the pyramid include more costly interventions directed toward a smaller number of people, designed to mitigate the acute and long-term impacts and negative consequences of the problem. In the middle of this pyramid sits *secondary prevention*, representing efforts to intervene early, when the problem has begun to appear, in order to stop, reverse, or delay the progression of the problem.

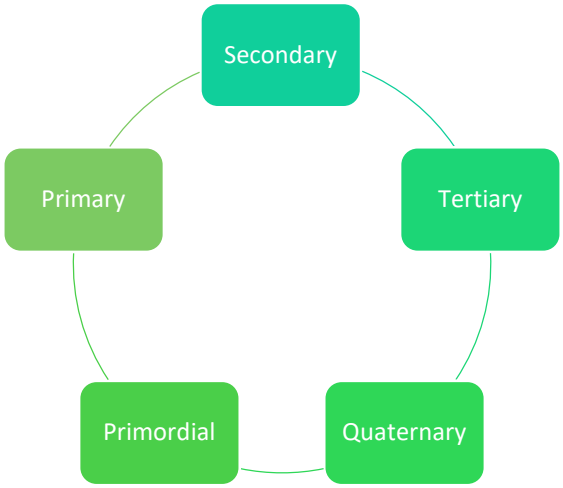
The greater the intensity of interventions required, the greater the cost of the services provided. These are located at the tip of the pyramid. The greatest potential for impact, with the broadest reach and lowest costs, is found at the base of the pyramid.

In violence intervention work, including the DV/IPV sector, the service delivery system operates as an "inverse pyramid," with the bulk of services directed at the fewest participants and with the highest costs. The middle of the pyramid represents early intervention opportunities and challenges, often neglected in the service delivery system in which services are directed to the high intensity, high-cost demands. Few would be willing to divert funds and services from those intended to prevent serious harm and even death.



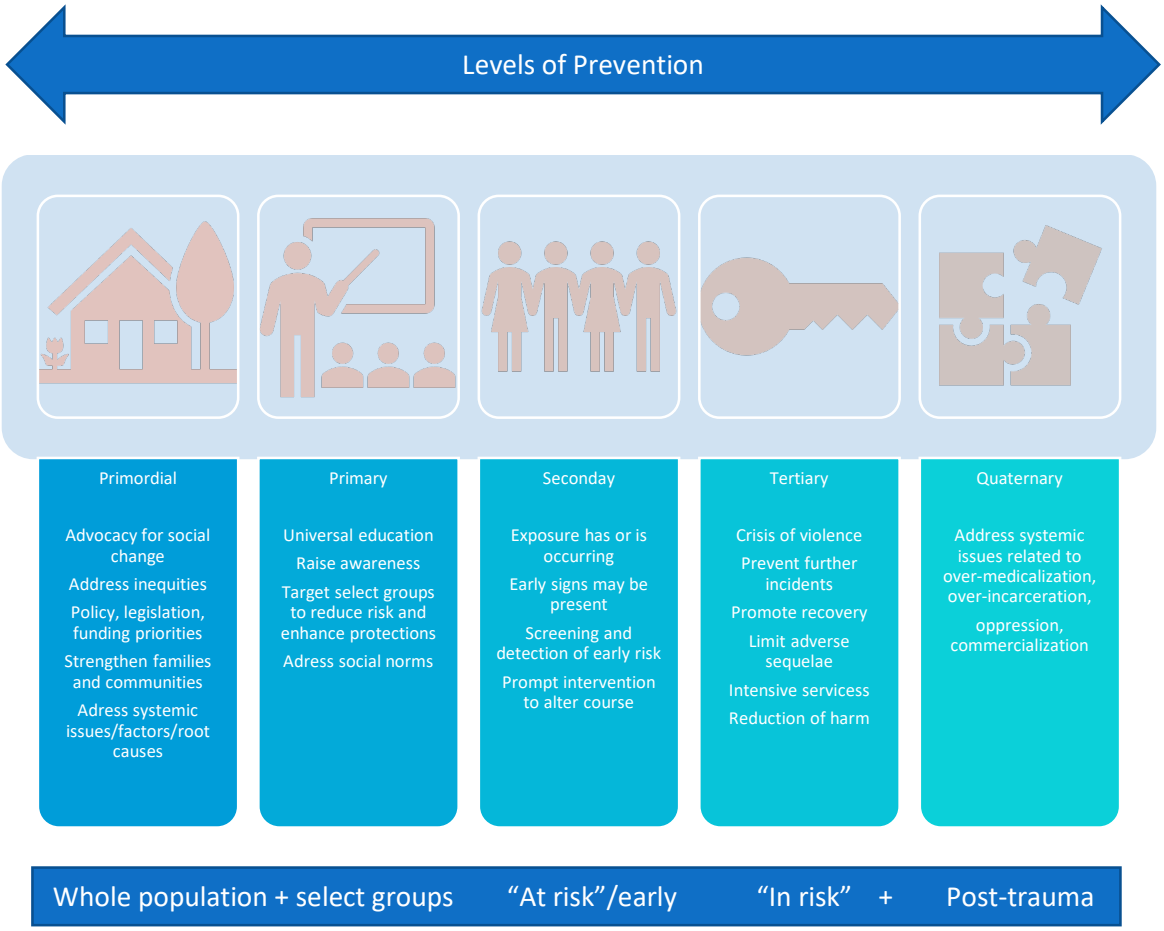
This prevention framework has proven to be more idealistic than realistic in the field of violence prevention. In responding to child maltreatment, intimate partner violence, and other forms of violence, the focus, interventions, and resources have been consistently directed to the *most acute cases* of violence. This has been driven by the need to intervene to prevent further serious harm, injury, and fatality, resulting in an "inverse" pyramid, in which the required intensity of treatment drives services, rather than the potential impact of earlier and more cost-effective intervention.

In addition, trends in prevention models have identified additional levels that expand the continuum of opportunities for prevention activity. These additions include a "*primordial*" level of prevention that addresses environmental, social, behavioral, cultural, and other systemic factors identified as risk factors, protective factors, or "root causes." At the far end of the spectrum is a "*quaternary*" level of prevention that seeks to redress the risk of "disease mongering" such as overmedicalization or commercialization. This has emerged as a more innovative model, encompassing 5 levels of prevention:



Public Health Approach to Prevention of Intimate Partner Violence: A Continuum

A preliminary model for this guide included developing a framework applying the 5 levels of prevention to the field of DV/IPV work along a continuum. A realistic model for the prevention of intimate partner violence is one that includes opportunities for some level of prevention across the spectrum of policies, programs, and services. Prevention is an effort to alter adverse consequences and can occur at different levels. This includes intervening at the following levels: primordial, primary, secondary, tertiary, and quaternary.



This model encourages and supports *collective action* in DV/IPV work through a more intentional approach to *multi-systems, multi-agency, cross-disciplinary* efforts. In the model, a DV/IPV agency may engage in advocacy, policy development, and community engagement to amplify the work occurring at service delivery levels. The agency may partner with other agencies engaging in education to reduce the risk factors that are correlated with other types of interpersonal violence. The agency may develop more programs and services accessible to those who are just beginning to experience the problem of interpersonal violence, including increased screening and prompt intervention to disrupt emerging

cycles or patterns of violence. DV/IPV agencies providing crisis response may include additional services and programs that strengthen capacity, and promote empowerment and growth post-trauma, to prevent further recurrences. In addition, DV/IPV agencies may participate in efforts to change systems of care that have had unintended negative consequences to participants.

A New Paradigm for Prevention Work in DV/IPV: A Matrix

Below is a "user friendly" functional model for those engaged in DV/IPV work. This work enhances the synchronicity and flow between levels of prevention and the ways in which this work is understood and practiced. In the model, primary prevention becomes ***education,*** secondary prevention becomes ***early intervention,*** tertiary prevention becomes ***crisis response,*** and the primordial and quaternary work that address systemic factors is integrated into the work of ***stabilization.***